U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 January 2007

In the Matter of:

E.M.,
Claimant

Case No.: 2003-BLA-0149

v.

ISLAND CREEK COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

E.M.,
Pro Se Claimant

Ashley M. Harman, Esq.
Jackson & Kelly, PLLC
Morgantown, West Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on August 10, 2004, in Beckley, West Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the

Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") at 32. Director's Exhibits ("DX") 1-54 and Employer's Exhibits ("EX") 1-3 and 9-11 were admitted into evidence without objection. Tr. at 14, 18-27. Employer's Exhibits 4-5 and 7-8 were excluded because they exceeded the limitations for the submission of evidence contained in 20 CFR § 725.414 (2006).[1] Tr. 22, 23, 24. Part of Employer's Exhibit 6 was admitted and the other part excluded. Dr. Wheeler's reading of the April 25, 2001, x-ray and his curriculum vitae were admitted. Dr. Zaldivar's reading of the same x-ray was excluded because it exceeds the evidentiary limitations in the regulations. The record was held open after the hearing to allow the parties to submit additional evidence and argument. The Employer submitted a closing argument, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence which do not exceed the limitations contained in the regulations, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed a claim for medical benefits on December 21, 1980. DX 1. This initial claim was not processed because the Claimant did not provide proof of entitlement to federal benefits. DX 1.

On December 15, 1993, the Claimant filed a claim for federal black lung benefits. DX 2. This claim was denied by the District Director of the Office of Workers' Compensation Programs (OWCP) on June 10, 1994, and again on September 1, 1994, on the grounds that the evidence did not show that the Claimant was totally disabled due to pneumoconiosis. The Claimant requested a hearing, which was held on March 27, 1995. Administrative Law Judge Edward Miller denied the claim in a Decision and Order dated March 8, 1996, finding that the Claimant was unable to establish that he suffered from pneumoconiosis.

The Claimant filed his current claim January 23, 2001. DX 4. The OWCP issued a proposed Decision and Order awarding benefits on June 25, 2002. DX 41. The Employer requested a hearing in a letter dated July 1, 2002. DX 43. The claim was referred to the Office of Administrative Law Judges on March 26, 2003. DX 52.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on January 23, 2001. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). Pursuant to 20 CFR § 725.309(d) (2006), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became

[1] The Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties. *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-169 (2004).

final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, and 718.204 (2006). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996).

ISSUES

The issues contested by the Employer are:

1. Whether the claim was timely filed.

2. The length of the Claimant's coal mine employment;

3. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

4. Whether his pneumoconiosis arose out of coal mine employment.

5. Whether he is totally disabled.

6. Whether his disability is due to pneumoconiosis.

7. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2006).

DX 52; Tr. at 12-13. The Employer also reserved its right to challenge the statute and regulations. DX 52; Tr. at 13. The Employer stipulated to 23 years of coal mine employment with Consolidated Coal Company. Tr. at 12.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified that he was 66 years old at the time of the hearing. Tr. 32. He has a sixth-grade education. Tr. 33. The Claimant testified that he has been married for 27 years; he has no other dependents. Tr. 32-33.

The Claimant alleged that he worked in the mines for 33 years. Tr. 12, 32. The Director found 29 years of coal mine employment. DX 41. The Employer stipulated to the 23 years of coal mine employment during which it employed the Claimant. Tr. 31. The Claimant left the mines in 1993 when he became disabled. Tr. 32, 34. His doctors pulled him out because of his lungs and his heart after he passed out shoveling snow in his driveway. Tr. 35, 39, 41. All of his coal mine work was underground. When he retired, he was doing general inside labor, which involved doing everything. He had to lift and carry up to 100 pounds in that job. Tr. 35-36. His

last coal mine employment was in West Virginia. Tr. 32. Therefore, this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

The Claimant is treated by Dr. Jarvis, whom he sees every two to three months. He was referred to Dr. Jarvis by Dr. Wall. He has never been hospitalized for his lung problems, but he has been for his heart. Tr. 37. He is using supplemental oxygen, and uses a Nebulizer twice a day. The Claimant testified that he smoked for about a year when he was 16 at a rate of a pack every week. Tr. 38.

Timeliness

The purpose of the regulation allowing the filing of subsequent claims, 20 CFR § 725.309 (2006), is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). The Benefits Review Board has held that there is no statute of limitations or time limit for filing a subsequent claim. *Andryka v. Rochester Pittsburgh Coal Co*., 14 B.L.R. 1-34 (1990). This view is not universally accepted by the Courts. *Compare Wyoming Fuel Co. v. Director, OWCP*, 90 F.3d 1502, 1507 (10th Cir. 1996) ("… a final finding by an … adjudicator that the claimant is not totally disabled due to pneumoconiosis repudiates any earlier medical determination to the contrary and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations."); *Westmoreland Coal Co. v. Amick*, 2004 WL 2791653, *3 (4th Cir. 2004) (unpub.) (rejecting the Board's view, but agreeing with *Wyoming Fuel*); *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608 (6th Cir. 2001) ("The three-year limitations clock begins to tick *the first time* that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and … may only be turned back if the miner returns to the mines after a denial of benefits.") (Emphasis in original). Applying the *Wyoming Fuel* standard to this case, Judge Miller found that the Claimant did not suffer from pneumoconiosis on March 8, 1996. There is no evidence in the file that he has ever been told that he is totally disabled by pneumoconiosis. At most, it appears that he was told by Dr. Jarvis and Dr. Wall that he had black lung and would not be able to work anymore in the coal mines. Tr. At 40-42. This recommendation, in and of itself, however, does not constitute an articulation of disability pursuant to the regulations or case law, as it does not foreclose comparable work in a dust-free environment. *See Zimmerman v. Director, OWCP*, 871 F2d 564, 567 (6th Cir. 1989). The Employer has offered no evidence or argument on this issue. I find that the claim is timely.

Material Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The first determination must be whether the claimant has established with new evidence that he suffers from pneumoconiosis or other pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such an impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on pulmonary or respiratory impairments. Nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits. 20 CFR

§ 718.204(a) (2006); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp*., 16 B.L.R. 1-11, 1-15 (1991), *aff'd*. 49 F.3d 993 (3d Cir. 1995). As will be discussed in detail below, the medical evidence filed in connection with his current claim does not establish that the Claimant has pneumoconiosis or any other pulmonary or respiratory impairment which is totally disabling. Thus, I find that he has not established that a material change in conditions has occurred. It follows that I do not need to address the evidence in the record from his previous claims in explaining my decision that he is not entitled to benefits.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print.[2]

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who classified opacities observed on x-ray have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), or the registry of physicians' specialties maintained by the American Board of Medical Specialties. [3]

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[2] Other x-ray readings on the table are from the Claimant's treatment records. A reading of the x-ray taken August 11, 1982, by Drs. MacCallum and Leef, performed in connection with the Claimant's state claim and submitted to the Department of Labor by the Employer, found in DX 34, has not been considered because it would exceed the limitations on medical evidence contained in the regulations.

[3] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the website of the American Board of Medical Specialties, found at http://www.abms.org.

If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
07/24/92			DX 24; EX 10 Patel Mild interstitial fibrosis
11/02/92			DX 24; EX 10 Patel Mild interstitial fibrosis Large pulmonary arteries; consider pulmonary hypertension
11/21/92			EX 10 Jarvis Mild interstitial fibrosis Large pulmonary arteries; consider pulmonary hypertension
12/13/97			DX 24; EX 10 Cruz Mild chronic interstitial lung changes. No acute infiltrates. No acute chest pathology
04/10/01		**DX 26 Wiot BCR/B** **DX 25; EX 11 Castle B** **ILO Classification 0/1**	
04/25/01	**DX 21, DX 23 Patel BCR/B** **ILO Classification 1/0**	**EX 6 Wheeler BCR/B**	**DX 22 Gaziano B** **Reviewed only for quality, Quality 1 (good).**

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Other tests appearing on the table were performed during treatment. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height[4]**	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 24; DX 34; EX 10 01/29/82 Wall	45 68"	3.49	4.03	86.4%		No	No obstructive defect. A restrictive defect cannot be excluded.
DX 24; EX 10 05/25/93 Jarvis	55 66"	3.23 3.15	3.65 3.55	88.63% 88.62%		No No	Spirometry within normal limits. No change after bronchodilator.
DX 25 04/10/01 Castle	**63 65"**	**2.67 2.77**	**3.52 3.45**	**76% 81%**	**88 88**	**No No**	**Normal. No evidence of obstruction or restriction. Normal diffusing capacity.**
DX 18 04/25/01 Mullins	**63 66"**	**2.50 2.76**	**3.22 3.42**	**78% 81%**	**69**	**No No**	**Normal except for reduced diffusing capacity (uncorrected for alveolar volume; normal when corrected).**

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 65" to 68", I have taken the mid-point (66.5") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in connection with the current claim in accordance with the limitations contained in 20 CFR § 725.414 (2006) appear in bold print. Other tests were performed during treatment. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006). The Claimant's treating physician, Dr. Jarvis, wrote a letter dated March 23, 2001, which the Claimant submitted to the Department of Labor. DX 17. In the letter, Dr. Jarvis stated:

> [The Claimant] has been under my care for a little more than ten years related to his pulmonary disease, as well as degenerative disc and joint disease in the lumbosacral spine, degenerative joint disease in the sacroiliac joints and in his right hip. As a result of these combined infirmities, it will not be possible for him to perform a cardiac or a pulmonary function test which would involve him walking on the treadmill for an adequate duration to be diagnostic.

Exhibit Number	**Date**	**Physician**	**pCO_2 at rest/ exercise**	**pO_2 at rest/ exercise**	**Qualify?**	**Physician Impression**
DX 24; EX 10	01/29/82	Wall	36.5	66.5	No	
DX 24; EX 10	01/04/93	Jarvis	37.4	73.6	No	
DX 24; EX 10	02/11/94	Jarvis	38.7	75.6	No	
DX 25	**04/10/01**	**Castle**	**37**	**78**	**No**	**Normal**
DX 16	**04/25/01**	**Mullins**	**46.6**	**91.7**	**No**	**ABG drawn on 2 liters of oxygen** **DX 19 Validated by Dr. Gaziano Board certified in internal medicine, chest disease and critical care (DX 20)**

Continued

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
Continued						**Drs. Jarvis, Fino and Mullins agreed this study did not give a true value, because the Claimant was still on his supplemental oxygen. DX 35, DX 40, EX 9.**

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contra-indicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions relating to this case.

The Employer submitted three pages of medical records from the Claimant's state black lung claim to the District Director, OWCP; those records were admitted into evidence at the hearing as DX 34. They include a medical report by Drs. MacCallum and Leef dated August 11, 1982; an x-ray reading by Dr. Leef; and a pulmonary function study performed for Dr. Wall. The Employer did not designate any of these records as initial evidence in support of its defense pursuant to 20 CFR § 725.414 in its Evidence Summary Form; rather it designated the medical reports of Dr. Castle and Dr. Fino described below; x-ray readings by Dr. Wiot and Dr. Castle, which appear on the table of x-ray readings above; and a pulmonary function study by Dr. Castle, which appears on the table of pulmonary function studies above. As the Employer is entitled to submit only two medical reports and two x-ray readings, I have not considered either

the medical report or the x-ray reading from the state claim. However, Dr. Wall was one of the Claimant's treating physicians, and treatment records are admissible without reference to the evidentiary limitations; and the Employer could have designated a second pulmonary function test, but did not. I have, therefore, included the pulmonary function test on the pertinent table above. In any event, as both the medical report and the x-ray reading report no pneumoconiosis, their exclusion has no effect on the outcome of the case.

The record contains miscellaneous treatment records from Drs. Wall and Jarvis. EX 10; DX 24. X-rays, pulmonary function tests, and arterial blood gas studies appear on the tables above. An echocardiogram taken May 4, 1998, showed no definitive features of marked pulmonary hypertension or right ventricular dysfunction.

Dr. Jarvis was deposed on April 24, 2001, concerning his treatment and testing of the Claimant. DX 40. Dr. Jarvis is Board-eligible in Internal Medicine and Nephrology. Dr. Jarvis stated that he has treated the Claimant for more than 10 years. He initially saw the Claimant for an acute respiratory infection. The Claimant's visits usually related to pulmonary problems, including shortness of breath, dyspnea on exertion, tiring easily, and not having stamina. His symptoms progressed over the years. Dr. Jarvis attributed the progression to a pulmonary disorder. Dr. Jarvis testified that the Claimant has pneumoconiosis "with a somewhat uncommon complication of pulmonary hypertension which is out of proportion to the degree of pneumoconiosis." He said that the Claimant developed pulmonary hypertension before hypoxemia and hypercarbia. Dr. Jarvis stated that he based his diagnosis of pneumoconiosis on Dr. Bembalker's previous diagnosis in 1993, and the diagnosis of pulmonary hypertension on x-ray and echocardiogram. Dr. Jarvis prescribed the supplemental oxygen, as well as multiple medications for allergies and arthritis. He had conducted arterial blood gas studies on the Claimant, but no pulmonary function or diffusing capacity studies. He agreed that the Claimant would be unable to return to the mines because of his orthopedic problems. He was not asked, and did not state, whether the Claimant would be unable to return to the mines because of his pulmonary problems.

Dr. Mullins examined the Claimant on behalf of the Department of Labor on April 25, 2001. DX 16. Dr. Mullins is Board-certified in Internal Medicine and Pulmonary Disease. DX 40. She took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. She reported that the Claimant worked in the mines for 33 years. She reported that the Claimant had never smoked. The chest examination revealed scattered rhonchi. Dr. Mullins relied on Dr. Patel's reading of the x-ray as showing coal workers' pneumoconiosis, 1/0. Dr. Mullins diagnosed chronic obstructive pulmonary disease based upon history, decreased DLCO, and chest x-ray evidence of coal workers' pneumoconiosis. In response to the question relating to the degree of impairment on the Department of Labor examination form, Dr. Mullins said that COPD constituted a 20% impairment, and the decreased DLCO constituted a 62% impairment in a non-smoker based on the 4th Edition of the *American Medical Association Guides to Evaluation of Permanent Impairment*. She assessed 100% disability based on degenerative joint disease of the spine and hips.

Dr. Jarvis wrote a letter to the Department of Labor dated December 11, 2001, stating that he had learned that the Claimant's blood gas study was undertaken while he was using his supplemental oxygen as prescribed. He said in order to obtain a valid reading, the Claimant

should have been off the oxygen for 30 minutes before the test. He requested that this information be taken into account in considering the claim. DX 35.

In a deposition taken on April 24, 2002, Dr. Mullins testified regarding her examination of the Claimant. DX 40. Dr. Mullins confirmed that she relied on Dr. Patel's reading of the x-ray as positive in diagnosing pneumoconiosis. She said that she diagnosed a lung impairment based on the reading of Claimant's diffusing capacity uncorrected for alveolar volume, which showed a reduced value; however, the corrected reading was normal. She agreed that the Claimant was using his supplemental oxygen when the arterial blood gas study was conducted. None of her results indicated pulmonary hypertension or cor pulmonale. She stated that if she read the objective data again, she would diagnosis "coal workers' pneumoconiosis by chest x-ray, . . . COPD with bronchospastic component by his pulmonary function test and symptoms, and coronary artery disease by history." Further, she stated that she would not find any impairment and would have completed the ABG study without the Claimant being on oxygen. She said, based on the objective testing, that the Claimant retained the pulmonary capacity to return to work in the mines, but he might be disabled based on the whole person.

Dr. Castle examined the Claimant on behalf of the Employer on April 10, 2001. DX 25. Dr. Castle is a B reader and is Board-certified in Internal Medicine and Pulmonary Disease. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. Additionally, Dr. Castle reviewed other medical data provided to him about the Claimant.[5] He reported that the Claimant worked in the mines for 33 years. He reported a smoking history of about one pack per week for about 18 months when he was 28 years old. The chest examination was normal. Dr. Castle read the x-ray as showing "a few increased irregular opacities of the s/t type in the right and left lower lung zones, possibly related to poor inspiration." Overall, Dr. Castle opined that the Claimant showed no evidence of pneumoconiosis. The pulmonary function test was normal. The arterial blood gas study was normal. Based upon his examination of the Claimant and review of his medical data, Dr. Castle concluded that the Claimant was not suffering from coal worker's pneumoconiosis based on physical findings, radiographic findings, and arterial blood gas findings. Additionally, Dr. Castle opined that the Claimant "does retain the respiratory capacity to perform any and all coal mining employment duties for which he has received training. He is not permanently and totally disabled as a result of coal workers' pneumoconiosis or as a result of any other process arising from his coal mining employment." Dr. Castle stated that it is possible that the Claimant is disabled as a result of cardiac disease.

In a deposition taken on March 17, 2003, Dr. Castle testified regarding his examination of the Claimant. EX 3. Dr. Castle reiterated the opinion he gave at the time of the examination. Prior to the deposition, Dr. Castle reviewed additional medical data. Dr. Castle testified that he did not see any blood gases indicating the need for supplemental oxygen. He said that pulmonary function testing from his own examination, and from Dr. Mullins', was normal. The Claimant was not using his supplemental oxygen during his examination by Dr. Castle, but his oxygen saturation was normal. Dr. Castle disagreed with Dr. Jarvis's diagnosis of pulmonary hypertension. He said there were no findings indicating either the presence of pulmonary

[5] According to his report, Dr. Castle read the report and x-ray reading by Drs. MacCallum and Leef, which I have found are not admissible. I find that his reference to this information was inconsequential to his opinion, as it was remote in time and essentially consistent with his interpretation of his own and other more recent examinations and testing.

hypertension or cor pulmonale. He said that the Claimant has a history of asthma, overweight, and heart disease, and all of those conditions can cause shortness of breath. He concluded that the Claimant does not have any significant pulmonary impairment, although he did have significant coronary disease, degenerative joint disease, and other medical problems that would interfere with his ability to work. Further, Dr. Castle testified that the Claimant does not suffer from either clinical or legal coal workers' pneumoconiosis.

Dr. Fino reviewed the Claimant's medical records and provided a report dated January 16, 2003. EX 1. Dr. Fino is Board-certified in Internal Medicine and Pulmonary Diseases, and a B reader. EX 2. Dr. Fino reviewed x-ray reports, pulmonary function studies, arterial blood gas studies, and medical reports. Dr. Fino opined that the Claimant does not have pneumoconiosis. He also found that the Claimant has no respiratory impairment. In addition, Dr. Fino opined that the Claimant is not partially or totally disabled from returning to his last coal mine job or job requiring similar effort.

Dr. Fino was deposed on April 17, 2003. EX 9. He reiterated the opinions stated in his reports. He also testified that abnormalities due to pneumoconiosis do not improve and in the Claimant's case, the abnormalities seen in earlier records have improved. Additionally, Dr. Fino testified that no evidence of cor pulmonale was seen on the x-ray evidence. Nor did he see any basis for prescribing supplemental oxygen in the Claimant's records. Dr. Fino reiterated the opinion he gave in his report that the Claimant does not have pneumoconiosis, or any pulmonary impairment.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited

to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Twenty CFR § 718.201 (2006).

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability is due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the claim was filed after January 1, 1982, and the Claimant is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The record contains several x-rays taken between 1992 and 1997 in connection with treatment which do not mention a diagnosis of coal workers' pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for

pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). In this case, all of the "silent" x-rays mention the presence of interstitial fibrosis. I find, therefore, that none are negative for pneumoconiosis.

Of the two x-rays taken in connection with the claim, one has been read by one, but not all reviewers, to be positive for pneumoconiosis, and one to be negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

Twenty CFR § 718.202(a)(1) (2006); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. The qualifications of a certified Radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The x-ray taken on April 10, 2001, was read as negative by Dr. Wiot, a Board-certified Radiologist and B reader, and Dr. Castle, a B reader. There are no positive readings. I, therefore, find this x-ray to be negative for pneumoconiosis.

The April 25, 2001, x-ray was read as positive by Dr. Patel, a Board-certified Radiologist and B reader, and negative by Dr. Wheeler, a Board-certified Radiologist and B reader. As the qualifications of the two readers are similar, I find that this x-ray is in equipoise, demonstrating neither the presence nor the absence of pneumoconiosis.

As the only two x-rays which have been classified as required by the regulations are either negative, or inconclusive, I conclude that the Claimant has not established the existence of pneumoconiosis by virtue of the x-ray evidence.

Turning now to the medical opinions, the Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-

155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a Judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." Twenty CFR § 718.104(d) (2006).

In this case, Dr. Jarvis is the Claimant's treating physician. However, Dr. Jarvis has no special qualifications as a pulmonologist, unlike Dr. Mullins, Dr. Castle, and Dr. Fino. Moreover, he said in his deposition that he relied on the diagnosis of another doctor in his assessment that the Claimant has pneumoconiosis. Furthermore, although he has been treating the Claimant for pulmonary hypertension, none of the Pulmonologists found any evidence to support that diagnosis, or for Dr. Jarvis' prescription of supplemental oxygen. Although x-ray readings in 1992 noted that pulmonary hypertension should be considered due to large pulmonary arteries, that diagnosis is not supported by the echocardiogram, which the other doctors indicated is a better diagnostic tool for that condition than x-ray. Nor do the results of the pulmonary function or blood gas studies support the need for supplemental oxygen. As a result of these problems, I find that Dr. Jarvis' opinion is not as well-documented or reasoned as the opinions of the Pulmonologists.

I find that all three of the remaining physicians' opinions in the record were documented and reasoned. All three are Board-certified in Internal Medicine and Pulmonary Disease. All had the opportunity to either examine the Claimant and administer objective tests, or review the Claimant's medical data. Dr. Mullins opined that the Claimant suffers from pneumoconiosis based upon x-ray evidence which I have found to be inconclusive. Drs. Castle and Fino, on the other hand, opined that the Claimant does not suffer from pneumoconiosis based on x-ray, histories and objective data in the record. A medical opinion better supported by the objective medical evidence of record is entitled to more weight. *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n.1 (1986). The x-ray evidence is the best available objective evidence on the condition of the Claimant's lungs. I accord greater weight to the opinions of Drs. Castle and Fino that the Claimant does not suffer from pneumoconiosis. These reports are better in accord with my findings that the chest x-ray evidence is inconclusive or negative. Since Dr. Mullins' diagnosis goes against the weight of the chest x-ray evidence, I accord her report less weight.

In the final analysis, I find that the Claimant has not established pneumoconiosis on the basis of medical opinion evidence.

Neither the x-ray evidence, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet his burden of showing that he has a pulmonary or respiratory disease attributable to his exposure to coal dust. Thus he cannot show that he is entitled to benefits under the Act.

Total Pulmonary or Respiratory Disability

Even were I to find that the Claimant had established that he has pneumoconiosis, his claim would still fail, because he has not established that he is totally disabled by a pulmonary or respiratory impairment.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 C.F.R. § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f); 20 C.F.R. § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. Twenty C.F.R. § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. Twenty C.F.R. § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no credible evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies, and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 C.F.R. § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

Addressing the pulmonary function studies first, all of the studies performed in connection with this claim are nonqualifying. Therefore, I cannot find disability based upon the pulmonary function studies.

Next, looking at the arterial blood gas studies, none are qualifying. Although the study taken during the Department of Labor examination may not have given a true picture of the Claimant's respiratory status because of his supplemental oxygen, the study taken by Dr. Castle two weeks earlier, without the supplemental oxygen, was also nonqualifying. Therefore, I cannot find disability based upon the arterial blood gas studies.

Finally, after analyzing the medical opinions of record, I cannot find disability. Dr. Jarvis testified that the Claimant is totally disabled by orthopedic problems, but he did not state that the Claimant is disabled by pulmonary problems. Dr. Mullins' initial finding on disability was

ambiguous, and at her deposition, she recanted her finding of a lung impairment based on a reduced DLCO, saying the Claimant has no pulmonary impairment. Drs. Castle and Fino opined from the outset that the Claimant has no pulmonary impairment, although Dr. Castle agreed with Dr. Mullins that he may be disabled by other medical problems. Drs. Castle and Fino based their opinions on pulmonary function studies, arterial blood gas studies, and other objective medical data in the record. Therefore, I find these reports to be both documented and reasoned. I accord probative weight to all three of these medical reports that the Claimant has no pulmonary impairment. Thus, I cannot find total disability based upon the medical opinions.

In the instant case, none of the pulmonary function or blood gas studies produced values indicative of total disability. Therefore, total disability cannot be established pursuant to 20 CFR § 718.204(b)(i) or (ii) (2006). Furthermore, of the physicians who provided medical opinions on pulmonary disability, Drs. Mullins, Castle, and Fino, all three found that the Claimant was not disabled by a pulmonary impairment. When these opinions are considered in conjunction with the results of the objective tests, I conclude that the Claimant has failed to establish that he is totally disabled by a pulmonary or respiratory impairment.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has failed to establish that he has pneumoconiosis arising out of his coal mine employment, or that he has a totally disabling pulmonary or respiratory impairment. Thus, the Claimant has not met his burden of showing a change in an applicable condition of entitlement pursuant to § 725.309(d), nor has he met his burden to show that he is totally disabled due to pneumoconiosis. Accordingly, the Claimant is not entitled to benefits under the Act.

ORDER

The claim for benefits filed by the Claimant on January 23, 2001, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).